

# Medicare Secondary Payer (MSP) Manual

## Chapter 1 - Background and Overview

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## **10 - General Provisions**

**(Rev. 1, 10-01-03)**

**B3-3328, A3-3418.2, PM97-14, B3-3329.1.C, A3-3491, A3-3491.12, HO-263, HO-263.12, SNF-336, SNF-336-12, HH-253, HO-264.12, SNF-335.12, HH-252.13**

Under the Medicare law, as enacted in 1965, Medicare was the primary payer for services except those covered by workers' compensation (WC). In 1980, Congress enacted the first of a series of provisions that made Medicare the secondary payer to certain additional third party payers (TPP). The purpose was to shift costs from the Medicare program to private sources of payment. [Section 1862\(b\)\(2\)\(A\)](#) of the Social Security Act (the Act) prohibits Medicare from making payment if payment has been made or can reasonably be expected to be made promptly by a third party payer. If payment has not been made or cannot be expected to be made promptly, Medicare may make a conditional payment subject to Medicare payment rules. At present, the law makes Medicare the secondary payer to insurance plans and programs under certain conditions, for beneficiaries covered for health care benefits through their group health plan (GHP) or a spouse's GHP or a family member's GHP and for auto, no-fault liability, and workers' compensation situations. When Medicare is secondary payer, the order of payment is the reverse of what it is when Medicare is primary. The other payer pays first and Medicare pays second.

When Medicare is the secondary payer, the provider, physician, supplier, or beneficiary must first submit the claim to the primary payer. The primary payer is required to process and make primary payment on the claim in accordance with the coverage provisions of its contract. The primary payer may **not** decline to make primary payment on the grounds that its contract calls for Medicare to pay first. If, after the primary payer processes the claim, it does not pay in full for the services, Medicare secondary benefits may be paid for the services as prescribed in [§10.8](#). Generally, the beneficiary is not disadvantaged where Medicare is the secondary payer because the combined payment by a primary payer and by Medicare as the secondary payer is the same as or greater than the combined payment when Medicare is the primary payer. Three provisions of the law require Medicare to be secondary payer relating to employer group health insurance plans. Three provisions of the law require Medicare to be secondary payer relating to

disease or accidents as a result of employment or coverage available under an automobile, liability insurance policy or plan (including a self-insured plan), or under no-fault insurance. An overview of each insurance type is separately described in the following sections. A detailed description of each insurance type is in Chapter 2 of the MEDICARE SECONDARY MANUAL (MSP).

## **10.1 - Working Aged**

**(Rev. 1, 10-01-03)**

**B3-3328.A.1, B3-3329.1.A, A3-3491, HO-262.2, HO-263, HO-263.1, SNF-332.2, SNF-336, SNF-336.1, HH-251.2, HH-253, HH-253.1, HO-264, SNF-335, HH-252**

Medicare benefits are secondary to benefits payable under GHPs for individuals age 65 or over who have GHP coverage as a result of:

- Their own current employment status with an employer that has 20 or more employees; or
- The current employment status of a spouse of any age with such an employer. (Section [70.2](#) of this chapter and §10 of Chapter 2 of the Medicare Secondary Payer (MSP) Manual further defines individuals subject to this limitation on payment.)

Employers are required to offer to their employees age 65 or over and to the age 65 or over spouses of employees of any age the same coverage as they offer to employees and employees' spouses under age 65, i.e., coverage that is primary to Medicare. This equal benefit rule applies to coverage offered to all employees (full-time and part-time).

Medicare beneficiaries are free to reject employer plan coverage, in which case they retain Medicare as their primary coverage. When Medicare is primary payer, employers cannot offer such employees or their spouses secondary coverage for items and services covered by Medicare. Employers may not sponsor or contribute to individual Medigap or Medicare supplement policies for beneficiaries with current employment status.

Health insurance plans for retirees or the spouses of retirees do not meet this condition and are not primary to Medicare. Medicare beneficiaries are free to reject GHP coverage in which case they retain Medicare as the primary coverage.

Only employers with 20 or more employees are required to offer the same (primary) coverage to their age 65 or over employees and the age 65 or over spouses of employees of any age that they offer to younger employees and spouses. This requirement is met if an employer has 20 or more full-time and/or part time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. Self-employed individuals who participate in an employer plan are not counted as employees in determining if the 20 or more employees requirement is met. Where an employer does not have 20 or more employees in the preceding year, he is required to offer his

employees and spouses age 65 or over, primary coverage when he has had 20 or more employees on each working day of 20 calendar weeks of the current year. The employer is then required to offer primary coverage for the remainder of that year and throughout the following year, even if the number of employees subsequently drops below 20. The "20 or more employees" requirement must be met when the individual receives the services for which Medicare benefits are claimed. If at that time, the employer has met the "20 or more employees" requirement in the current year or in the preceding calendar year, the GHP is primary payer. An employer that meets this requirement must provide primary coverage even if less than 20 employees participate in the employer plan.

Employers are not required to provide coverage to individuals. However, any coverage provided to such individuals age 65 or older and age 65 or older spouses of such individuals of any age, by an employer of 20 or more employees must be the same as coverage provided to younger such individuals, that is, coverage primary to Medicare. The employer must also provide primary coverage to older such individuals even if there are no younger such individuals enrolled in the plan.

Where a GHP is primary payer, but does not pay in full for the services, secondary Medicare benefits may be paid, to supplement the amount it paid for the Medicare covered service. If a GHP denies payment for services because they are not covered by the plan as a plan benefit bought for all covered individuals, primary Medicare benefits may be paid if the services are covered by Medicare. Primary Medicare benefits may **not** be paid if the plan denies payment because the plan does not cover the service for primary payment when provided to Medicare beneficiaries.

A GHP's decision to pay or deny a claim because the services are or are not medically necessary is not binding on Medicare. Contractors must evaluate claims under existing guidelines derived from the law and regulations to assure that services are covered by the program regardless of any employer plan involvement.

Contractors assume for developing claims and the requirement that GHPs be billed before Medicare that, in the absence of evidence to the contrary, an employer in whose health plan a beneficiary is enrolled because of employment meets the definition of employer and employs at least 20 people. The contractor refers an employer's allegation that the 20-employee requirement is not met to the COB contractor.

Contractors should refer a multi-employer plan's (a plan sponsored by or contributed to by two or more employers or employee organizations) statement identifying specific members as employees of employers of few than 20 employees, as a basis for making Medicare primary payer, to the contractor in the State in which the multi-employer plan is located for development as a prospective exemption request.

NOTE: The request to exempt is done on a prospective basis.

## **10.2 - End-Stage Renal Disease (ESRD)**

**(Rev. 1, 10-01-03)**

**AB-97-14, A3-3490, B3-3329.B, B3-3329.1, HO-264, HO-264.1, SNF-335.1, HH-252.1, B3-3328.A3**

Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to benefits on the basis of ESRD (see Medicare General Information, Eligibility and Entitlement Manual, Chapter 2, "Hospital Insurance and Medical Insurance") during a period of up to 30 months if Medicare was not the proper primary payer for the individual on the basis of age or disability at the time that this individual became eligible or entitled to Medicare on the basis of ESRD

The coordination period begins when the individual is eligible for Medicare. Medicare is secondary during this period even if the employer policy or plan contains a provision stating that its benefits are secondary to Medicare, or otherwise excludes or limits its payments to Medicare beneficiaries. Under this provision, the GHP is billed first for services provided to a Medicare ESRD beneficiary. If the GHP does not pay for covered services in full, Medicare may pay secondary benefits in accordance with current billing instructions. This provision applies to all Medicare covered items and services (not just treatment of ESRD) furnished to beneficiaries who are in the coordination period.

## **10.3 - Disabled Beneficiaries Covered Under a Large Group Health Plan (LGHP)**

**(Rev. 1, 10-01-03)**

**B3-3329.1.C, SNF-337. B3-3337.1**

Medicare benefits are secondary payer to "large group health plans" (LGHP) for individuals under age 65 entitled to Medicare on the basis of disability and whose LGHP coverage is based on the individual's current employment status or the current employment status of a family member. Under the law, a LGHP may not "take into account" that such an individual is eligible for, or receives, Medicare benefits based on disability. The instructions in §10.1 and throughout this manual that are applicable to GHPs are also applicable to LGHPs in processing claims where Medicare is secondary payer for disabled individuals. Where those sections refer to a GHP of 20 or more employees, substitute the term "large group health plan" as defined in §20, to apply them to disabled individuals.

Medicare benefits are secondary to benefits payable under a LGHP for individuals under age 65 entitled to Medicare on the basis of disability who are covered under a LGHP as a result of the:

- Individual's current employment status with an employer that has 100 employees or more (see Chapter 2, §30.3); or

- Current employment status of a family member with such employer.

Special rules apply in the case of multiple employers and multi-employer plans. (See Chapter 2, §30.3.) Medicare is secondary for these Medicare beneficiaries even though the employer policy or plan contains a provision stating that its benefits are secondary to Medicare benefits or otherwise excludes or limits its payments to Medicare beneficiaries.

Medicare is secondary payer to LGHP coverage based on an individual's or family members current employment status for services provided on or after August 10, 1993.

## **10.4 - Workers' Compensation (WC)**

**(Rev. 1, 10-01-03)**

**B3-3328.4, B3-2370, A3-3407, HO-289, SNF-325, HH-250**

Medicare is secondary to WC plans (including black lung benefit programs). (See Chapter 5, §20.3.) Payment under Medicare may not be made for any items and services to the extent that payment has been made or can reasonably be expected to be made for such items or services under a workers' compensation (WC) law or plan of the United States or any State. If it is determined that Medicare has paid for items or services that can be or could have been paid under WC, the Medicare payment constitutes an overpayment.

This limitation also applies to the WC plans of the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands. It also applies to the Federal WC plans provided under the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal Black Lung Program). These Federal programs provide WC protection for Federal civil service employees and certain other categories of employees not covered, or not adequately covered, under State WC programs, e.g., coal miners totally disabled due to pneumoconiosis, maritime workers (with the exception of seamen), employees of companies performing overseas contracts with the United States government, employees of American companies who are injured in an armed conflict, employees paid from nonappropriated Federal funds (such as employees of post-exchanges), and offshore oil field workers. The Federal Employers' Liability Act, which covers merchant seamen and employees of interstate railroads, is not a WC law or plan for purposes of this exclusion. Similarly, some States have employers' liability acts. These also are not considered WC acts for purposes of this exclusion.

All WC acts require that the employer furnish the employee with necessary medical and hospital services, medicines, transportation, apparatus, nursing care, and other necessary restorative items and services. However, in some States there are limits to the amount of medical and hospital care provided. For specific information regarding the WC plan of a particular State or territory, contact the appropriate agency of that State or territory.

If payment for services cannot be made by WC because they were furnished by a source not authorized by WC, such services can be paid for by Medicare.

The beneficiary is responsible for taking whatever action is necessary to obtain payment under WC where payment under that system can reasonably be expected (e.g., timely filing a claim, furnishing all necessary information). If failure to take proper and timely action results in a loss of WC benefits, Medicare benefits are not payable to the extent that payment could reasonably have been expected under WC.

## **10.5 - No-Fault Insurance**

**(Rev. 1, 10-01-03)**

**B3-3328.5, B3-2340, HO-262.8**

Medicare is secondary to any no-fault insurance, including automobile medical and non-automobile no-fault insurance. (See Chapter 2, §60.) No-Fault insurance is a form of insurance that makes payment for medical and other expenses incurred as a result of an accident without regard to the contributory fault of any party to the accident. MedPay is a form of no-fault insurance. Payment may not be made under Medicare for otherwise covered items or services to the extent that payment has been made, or can reasonably be expected to be made, for the items or services under an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance.

## **10.6 - Liability Insurance**

**(Rev. 1, 10-01-03)**

**B3-3328.6, A3-3418, A3-3489, HO-262, SNF-332, HH-251, A3-3418.2.F**

Medicare is secondary to any liability insurance (e.g., automobile liability insurance and malpractice insurance). (See Chapter 2, §40.) Liability insurance means insurance (including a self-insurance plan) that provides payment based on legal liability for injury or illness or damage to property, homeowners' liability insurance, malpractice insurance, product liability insurance and general casualty insurance. It includes payments under state "wrongful death" statutes that provide payment for medical damages.

## **10.7 - Conditional Primary Medicare Benefits**

**(Rev. 1, 10-01-03)**

**B3-3328.C, A3-3491.9.A, B3-2370.6.B, A3-3415, B3-3333.A, HO-263.10, HO-289.21, SNF-3301, SNF-336.10, HH-250.20, HH-253.10**

There is frequently a long delay between the occurrence of an injury and the decision by the State WC agency in cases where compensability is being contested or in a comparative liability action. A denial of Medicare benefits pending the outcome of the final decision means that beneficiaries might be required to advance their own funds to

pay for expenses that are eventually borne by WC, the liability insurer, the no-fault insurer, or Medicare. To avoid imposing a hardship on Medicare beneficiaries pending such decision, conditional Medicare payments may be made. Such payments are conditioned upon reimbursement to the trust fund if it is later determined that the services are covered by WC, no-fault insurer, or the liability insurer.

Conditional payments may also be paid for services denied by a GHP in situations identified in §10.7.1, below.

**NOTE:** If the injury resulted from an automobile accident and/or there is an indication of primary coverage under a GHP, the provider bills the automobile medical or no-fault insurer and/or GHP as appropriate, in accordance with [§10](#), [§10.2](#), and [§10.6](#), before requesting conditional Medicare payments. (See [§10.9](#) and Chapter 2, §50.2.)

### **10.7.1 - When Conditional Primary Medicare Benefits May Be Paid**

**(Rev. 1, 10-01-03)**

**A3-3491.9.B, B3-3328.C, B3-3338.3, HO-263.10, SNF-336.10, HH-253.10**

Conditional primary Medicare benefits may be paid if:

- The beneficiary, provider, physician, or supplier has filed a proper claim with a GHP in the case of services for which payment under WC, or liability, or no-fault insurance can reasonably be expected, and the contractor determines that the GHP insurer will not pay promptly (i.e., within 120 days of receipt of the claim) for any reason except when the GHP claims that its benefits are secondary to Medicare; or
- The beneficiary or provider, physician, or supplier that has accepted assignment filed a proper claim with a GHP or LGHP and the GHP denied the claim in whole or in part; or
- Because of physical or mental incapacity of the beneficiary, the physician, the supplier or beneficiary failed to file a proper claim with the GHP.

When such conditional Medicare payments are made, they are made on condition that both the insurer and beneficiary will reimburse the program to the extent that payment is subsequently made by the GHP.



## **10.7.2 - When Conditional Primary Medicare Benefits May Not Be Paid**

**(Rev. 1, 10-01-03)**

**B3-3328.C.2, A3-3491, A3-3491.9.C, HO-263, HO-263.10, SNF-336, SNF-336.10, HH-253, HH-253.10**

Conditional primary Medicare payments may not be made under either of the following circumstances:

A - The claim is denied for one of the following reasons:

- It is alleged that the TPP plan is secondary to Medicare;
- The plan limits its payment when the individual is entitled to Medicare;
- The services are covered by the TPP for younger employees and spouses but not for employees and spouses age 65 or over; or
- Failure to file a proper claim (including failure to file timely) if that failure is for any reason other than physical or mental incapacity of the beneficiary.

B - The GHP fails to furnish information requested by CMS as necessary to determine whether the employer plan is primary to Medicare.

## **10.8 - When Medicare Secondary Benefits Are Payable and Not Payable**

**(Rev. 1, 10-01-03)**

**B3-3328.18, B3-3328.19, A3-IM 3497, A3-IM 3497.3 (This supersedes §3407.2.A and 3490.8), A3-IM 3497.4 (This supersedes §3407.3, 3490.B.3, and 3491.11)**

Contractors may pay Medicare secondary benefits when a provider, physician, supplier, or beneficiary submits a claim to a TPP and the TPP does not pay the entire charge. Medicare will not make a secondary payment if the provider/physician/supplier accepts, or is obligated to accept, the TPP payment as full payment. (In the case of liability claims (see Chapter 2, §40), the TPP may be billed only during the 120-day promptness period by providers and physicians/suppliers who have accepted assignment.) The method of calculating the Medicare secondary amount is the same whether the claim is assigned or unassigned.

When a third party payment for Medicare covered services is less than the provider's charges for those services and less than the gross amount payable by Medicare, and the provider does not accept and is not obligated to accept the third party payment as full payment, then contractors can process Medicare secondary payment in accordance with Chapter 5, §40.8.2, as appropriate.

Secondary benefits are not payable when the:

- TPP pays the provider/physician's/supplier's charges in full; or
- Provider/physician/supplier is either obligated to accept or voluntarily accepts a third party payment as full payment; or
- The third party payment is equal to or greater than the gross amount payable by Medicare, e.g., providers participating with Blue Cross/Blue Shield are usually required to accept Blue Cross/Blue Shield payment as payment in full.

## **10.9 - Multiple Insurers**

**(Rev. 1, 10-01-03)**

**B3-3328.10, A3-3491.6.C, HO-263.7, SNF-336.7, HH-253.7**

### **A - More Than One Primary Insurer**

**B3-3328.10.A, A3-3491.6.C, A3-3408.1.B, HO-263.7, HO-289.12, SNF-327.1, SNF-336.7, HH-250.12, HH-253.7**

There may be instances where Medicare is secondary payer to more than one primary insurer (e.g., an individual who meets the criteria in [§70](#) is covered under his/her own GHP and under the GHP of an employed spouse (who also meets the criteria in [§70.2](#)) or under no-fault insurance). In such cases, the other primary payers will customarily coordinate benefits. If a portion of the charges remains unpaid after the other insurers have paid primary benefits, a secondary Medicare payment may be made.

Coordination of benefits arrangements between private plans, whether based on State law or private agreements, cannot supersede Federal law that makes Medicare secondary payer to certain GHPs for individuals and spouses age 65 or over. Therefore, where the individual has GHP coverage based on current employment status in addition to GHP coverage as a retiree, Medicare is secondary to the GHP coverage based on current employment status and primary to the GHP coverage based on retirement regardless of the coordination of benefits arrangements between the plans.

Where services are covered in part by WC and also under automobile medical or no-fault insurance, or there is primary coverage by a GHP, Medicare is the residual payer only. (See §10, Chapter 5, §20.2 and §30.1, and Chapter 2, §30, respectively.)

Accordingly, whenever WC pays in part for provider services and the provider does not accept, and is not obligated to accept the payment as payment in full, the provider assures that a claim is submitted to any other insurer that is primary to Medicare.

## **B - Coordination of Benefits Rules Conflict With MSP Rules**

### **B3-3328.10.B, A3-3491.6.C, HO-263.7, SNF-336.7, HH-253.7**

Coordination of benefits arrangements between private plans, whether based on State law or private agreements, cannot supersede Federal law that makes Medicare secondary payer to GHPs and LGHPs in certain situations. There are two scenarios to consider.

The first scenario is where an individual has dependent GHP coverage that is primary to Medicare (e.g., coverage based on the employment of the individual's spouse) in addition to nondependent coverage that is secondary to Medicare (e.g., coverage based on the individual's retirement), Medicare is secondary to the dependent coverage and primary to the nondependent coverage. In other words, the dependent coverage pays first and the nondependent coverage pays second even though under private coordination of benefits agreements, the nondependent coverage would be expected to pay before the dependent coverage. (See example 2 below.)

The second scenario is where a plan's payment would normally be secondary to Medicare but, under coordination of benefit provisions, the payment is primary to a primary payer under [§1862\(b\)](#) of the Act, the combined payment of both plans constitutes the primary payment to which Medicare is a secondary payer. In other words, both plans pay first. (See example 1 below.)

#### **EXAMPLE 1**

John Jones, age 75, is a Medicare beneficiary with coverage under Part A and Part B. He retired from the Acme Tool Company in 2003 and received retirement health insurance coverage that is secondary to Medicare. His wife, Mary, age 64, has been employed continuously with the local police department since 1977 and since that time has received coverage for herself and her husband under the department's GHP. The priority of payment for John's medical expenses is as follows:

- The GHP of the spouse who has current employment status is primary payer. Medicare will not pay until GHP of the spouse has made a full primary payment.

The GHP of the spouse may **not** assert that, under its private COB rules, it would only be liable for deductible and coinsurance and thus only pay the estimated deductible and coinsurance. It must make a full primary payment.

- Medicare is secondary payer.

**NOTE:** If the retirement plan is permitted to pay after the GHP under the private coordination of benefits, the order of payment will be as follows:

- The GHP will be primary,
- Medicare will be secondary, and

- The retirement plan will be tertiary payer.

## **EXAMPLE 2**

Chris Thomas, age 67, is a Medicare beneficiary with coverage under Part A and Part B. He has been employed continuously by XYZ Bolt Company since 2002 and has GHP coverage through his employer. His wife, Ann, age 62, has been retired from the local police department since 2000 and received retirement health insurance coverage for herself and her husband that is secondary to Medicare. The order of payment for Chris' medical expenses is as follows:

- Chris's GHP, based on current employment status is primary payer.
- Medicare is secondary payer.
- The spouse's retirement plan is the tertiary payer.

## **20 - Definitions**

(Rev. 1, 10-01-03)

**B3-3329.2, A3-3490.1, A3-3491, A3-3489.1, A3-3418.2, B3-2370.1, A3-3492, A3-3491.1.C, B3-3328, B3-3340.2.D, A3-3218.2, HO-262.2, HO-262.8 HO-262.9, HO-263, HO-263.2, HO-264.2, HO-289.1, A3-IM 3492, A3- IM 3497.1, A3- IM 3497.6, A3- IM 3497, A3-3407.1, B3-3338.2, SNF-332.3, SNF-334.1, SNF-336, SNF-336.2, HH-253.2, SNF-335.2, HH-252.2, SNF-325.1, HH-248.1, HH-250.1, HH-251.2, HH-253, PM-AB-00-27, B3-7080.1, A3-3492.B.3**

**Accident** - An unintended occurrence outside the normal course of events that causes illness, injury, or damage to a person or property.

**Active Individual** - The term "active individual" means "an employee, the employer, self-employed individual, an individual associated with the employer in a business relationship, or a member of the family of such persons."

**Age 65 or older** – An individual attains age 65 on the day preceding his or her 65<sup>th</sup> birthday.

**Automobile** - Any self-propelled land vehicle of a type that must be registered and licensed in the State in which it is owned.

**CMS' Claim** - The amount that is determined to be owed to the Medicare program. This is the amount that was paid out by Medicare, less any applicable procurement costs.

**Consolidated Omnibus Budget Reconciliation Act** of 1985 (COBRA) is a Title X provision that provides continuation of GHP coverage if elected. For aged or disabled Medicare beneficiaries, COBRA continuation coverage is secondary to Medicare because the coverage is by virtue of COBRA law rather than by virtue of current employment

status. For an ESRD related Medicare beneficiary, COBRA continuation coverage if elected, is primary to Medicare during the 30-month ESRD coordination period. See [42 CFR 411.161\(a\)\(3\)](#) and [411.162\(a\)\(3\)](#).

**Compromise** - A settlement of differences by mutual consent or adjustment of matters in dispute by mutual concession; a negotiated settlement between parties who are in essentially equal bargaining positions, wherein neither party admits or concedes that he is entitled to less than he desires, but accepts less to effect the goal of ending the dispute. In an MSP situation under the Federal Claims Collection Act, a compromise represents the acceptance by CMS or the Regional Office (RO) of less than the full debt owed to Medicare, when the amount of the full debt does not exceed \$100,000, or by Central Office (CO) when the amount exceeds \$100,000. An individual who accepts a compromise has no right to appeal the remaining debt.

**Conditional Payment** - A Medicare payment for services for which another insurer is primary payer. See §10.7 for situations identifying when conditional payment may be made.

**Coordination Period** - The term "coordination period" means a period of 30 months during which Medicare benefits are secondary to benefits payable under GHPs for individuals who have Medicare because of ESRD. See Chapter 2, §20.

**Current Employment Status** – See [§50](#) of this chapter.

**Eligibility** - Eligibility means a beneficiary meets the legal requirements for Medicare benefits. It is still necessary to file an application to become entitled. (For example, a Social Security beneficiary is eligible for Medicare upon attaining age 65 but is not entitled until an application is filed and approved).

**Employee** - An individual who is working for an employer or an individual who, although not actually working for an employer, is receiving from an employer payments that are subject to FICA taxes or would be subject to FICA taxes except that the employer is exempt from those taxes under the Internal Revenue Code (IRC).

**Employer** - Employer means, in addition to individuals (including self-employed persons) and organizations engaged in a trade or business, other entities exempt from income tax such as religious, charitable, and educational institutions. Included are the governments of the United States, the individual States, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the District of Columbia, and foreign governments.

**Employer Group Health Plan or Employer Plan** – This means any health plan that is of, or contributed to by, an employer; and that provides medical care, directly or through other methods such as insurance or reimbursement to current or former employees, and/or their families. It includes the Federal employees health benefits program but not TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). “Employee pay all” plans, i.e., group health plans under the auspices of an employer which do not receive any contributions from the

employer, also meet the definition. Individual policies (including Medigap policies) purchased by or through an employee organization, employer or former employer of the individual or family member of the individual are considered employee offered GHPs. However, coverage under TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), is **not** considered to meet the definition of GHP.

Contractors assume in the absence of evidence to the contrary, that any health plan (including a union plan) in which a beneficiary is enrolled because of current or former employment of the beneficiary or of a member of the beneficiary's family meets this definition.

**Entitled** - An eligible individual becomes entitled to Medicare by filing the appropriate application. Upon approval of the application, the individual is entitled. It may also be necessary to enroll for certain services in order to get them.

**Family Member** - Family member means a person enrolled in a GHP based on another person's enrollment. Family members may include a spouse (including a divorced or common law spouse); a natural, adopted, or foster child; a stepchild; a parent; or a sibling.

**FICA** - The term "FICA" stands for the Federal Insurance Contributions Act, the law that imposes Social Security taxes on employers and employees under §21 of the Internal Revenue Code.

**Fiduciary** - A person in a position of trust with regard to the affairs of another, who has a duty to act primarily for the benefit of the other, with respect to a particular undertaking.

**GHP (Group Health Plan)** - The term "GHP" means any arrangement of, or contributed to by, one or more employers or employee organizations to provide health benefits or medical care directly or indirectly to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. An arrangement by more than one employer is considered to be a single plan if it provides for common administration of the health benefits (e.g., by the employers directly or by a benefit administrator or by a multi-employer trust or by an insuring organization under a contract or contracts).

A plan that does not have any employees or former employees as enrollees (e.g., a plan for self-employed persons only) does not meet the definition of a GHP and Medicare is not secondary to it. Thus, if an insurance company establishes a plan solely for its self-employed insurance agents, other than full-time life insurance agents, the plan is not considered a GHP. However, if the plan includes full-time life insurance agents or other employees or former employees, it is considered a GHP.

The term "GHP" includes self-insured plans, plans of governmental entities (Federal, State, and local such as the Federal Employees Health Benefits Program), and employee organization plans. Examples of the latter are union plans and employee health and welfare funds. Employee-pay-all plans are also included (i.e., GHPs which are under the

auspices of one or more employers or employee organizations but which do not receive any contribution from the employer). Individual policies (including Medigap policies) purchased by or through an employee organization, employer or former employer of the individual or family member of the individual are considered employer offered GHPs. However, coverage under the TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is not considered to meet the definition of a GHP. It is secondary to Medicare since the law makes Medicare primary to TRICARE.

Any health plan (including a union plan) in which a beneficiary is enrolled because his/her employment or a family member's employment meets this definition.

**Judgment** - The official and authentic decision of a court of justice upon the respective rights of the parties to an action submitted to it for determination.

**LGHP (Large Group Health Plan)** - LGHP means a GHP that covers employees of either:

- A single employer or employee organization that employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year; or
- Two or more employers or employee organizations at least one of which employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year.
- It includes individual policies (including Medigap policies) purchased by an or through an employer or former employer of the individual or family member.

**Liability** - Responsibility or fault for damages arising out of a specified incident.

**Liability Insurance** - Insurance (including a self-insured plan) that provides payment based upon a legally established responsibility for injury, illness or damage to property. It includes, but is not limited to, automobile liability, uninsured and under-insured motorist, homeowner's liability, malpractice, product liability and general casualty insurance. It includes payments under State "wrongful death" statutes that provide payment for medical damages.

**Liability Insurance Payment** - A payment by a liability insurer, including a payment to cover a deductible required by a liability insurer, by any individual or other entity that possesses liability insurance or is covered by a self-insured plan.

**Lump Sum Commutation Settlement** - The beneficiary accepts a lump sum payment that compensates for all future medical expenses and disability benefits related to the work injury or disease.

**Lump Sum Compromise Settlement** - A settlement that provides less in total compensation than the individual would have received if he or she had received full

reimbursement for lost wages and life long medical treatment for the injury or illness. This may occur when compensability is contested.

**MSP** - Acronym denoting "Medicare Secondary Payer" provision of the Social Security Act. Medicare has a responsibility to pay for covered medical expenses only after (i.e. secondary to) another insurer who is deemed the primary payer has made payment. The statute intentionally shifts the financial burden for covered medical expenses from Medicare to other insurers whom Congress has determined must be primary payer. Section [1862\(b\)\(2\)\(A\)](#) prohibits Medicare from making payment if payment has been made or can reasonably be expected to be made promptly by a third party payer. If payment has not been made or cannot be expected to be made promptly, Medicare may make a conditional payment, subject to Medicare payment rules.

**Med-Pay** - A payment made by an insurer intended specifically to pay for medical expenses without regard to the fault of any party to the accident. Med-Pay is a form of no-fault insurance/personal injury protection insurance. In these situations, Medicare's proportionate share of procurement costs is not deducted from this payment unless the claim was contested.

**Multi-employer Group Health Plan** - The term "multi-employer group health plan" means a plan that is sponsored jointly by two or more employers (sometimes called a multiple employer plan) or by employers and unions (as under the Taft-Hartley law).

**No-Fault Insurance** - Insurance that pays for medical expenses for injuries sustained or on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, homeowners, and commercial plans. It is sometimes called "medical payments coverage," "personal injury protection," or "medical expense coverage." Examples of no-fault insurance include automobile no-fault insurance, often referred to as personal injury protection (PIP), and homeowners and commercial medical payments insurance, commonly referred to as Med-pay coverage. In these situations, Medicare's proportionate share of procurement costs is not deducted from this payment unless the claim was contested.

**Nonconforming Group Health Plan or Large Group Health Plan** - A "nonconforming GHP or LGHP" means one that at any time during the calendar year takes into account that an individual is eligible for, or receives, benefits based on disability, e.g., a LGHP fails to pay primary benefits for disabled individuals under age 65 for whom Medicare is secondary payer in accordance with these instructions.

**Partial Waiver** - A decision by the Medicare program to relinquish the right to collect from a specific entity. A partial waiver is not to be confused with a compromise. It is different in that it does not arise from negotiation or offer, but under [1870\(c\)](#) of the Act, which provides the beneficiary the right to request waiver and Medicare the authority to grant or deny waiver based on factual data. Section 1870(c) allows a partial waiver to a person who is without fault or where the adjustment or recovery would defeat the purpose of Title II or XVII of the Act (hardship) or be against equity and good conscience. An



individual may appeal a determination based on 1870(c) of the Act if the determination grants only partial waiver of a debt. The CMS also has the right to grant partial waivers as set forth in [1862\(b\)\(2\)\(B\)\(iv\)](#) of the Act if it is in the best interests of the Program. Waiver decisions of MSP debts based upon 1862(b)(2)(B)(iv) may not be appealed.

**Payment in full** – Payment in full is an amount that the provider is obligated to accept (e.g., contractually) or voluntarily accepts as payment in full from the insurer (i.e., the GHP) in full satisfaction of the patient's payment obligation. Because Medicare payments are made on behalf of the beneficiary, satisfaction of a patient's payment obligation satisfies any Medicare payment obligation.

**Plan** - The term "plan" means any arrangement by an employer or by more than one employer, or by an employee organization to provide health benefits or medical care to employees. An arrangement by more than one employer is a single plan if the arrangement provides for common administration of the health benefits. An arrangement may be administered by the employers directly, by a benefit administrator, by a multi-employer trust, or by an insuring organization under a contract or contracts which stipulate that the organizations provide all employees enrolled in the plan the same benefits or the same benefit options.

**Proceeds** - Money or items of value obtained as a result of a transaction, which are in the possession of the party to whom they were intended to be disbursed.

**Procurement Costs** - Attorney fees and other costs directly related to securing a settlement or judgment that are borne by the party against which CMS seeks to recover.

**Prompt or Promptly** - With regard to liability insurance means payment within 120 days after the earlier of the following:

- The date a claim is filed with an insurer or a lien is filed against a potential liability settlement; or
- The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

With regard to all other primary payers, prompt or promptly means payment within 120 days after receipt of the claim.

**Proper Claim** - A claim that is filed timely and meets all other claims filing requirements specified by the TPP (e.g., mandatory second opinion, prior notification before seeking treatment).

**Recovery** - Proceeds obtained from a judgment, settlement, erroneous or conditional payment. The establishment of a right existing in an individual through a law, formal judgment, or decree of a court.

**Secondary** – The term "secondary", when used with respect to Medicare payment, means that Medicare is the residual payer to all GHPs under which the Medicare beneficiary is

covered and will not pay for expenses that are reimbursable by any such plan. Consider the WC exclusion (§10.4 and Chapter 2 §50) and no fault and liability insurance provisions (Chapter 2 §20 and, §60) in determining the extent of Medicare's liability as a residual payer. If Medicare is secondary payer to more than one primary insurer, e.g., an individual covered under his own GHP as well as under the GHP of his spouse or under automobile insurance, the other primary payer(s) will customarily coordinate benefits.

Medicare secondary payment is made only after all primary payers have made proper primary payments.

**Self-Employed Person** - An individual is considered to be self-employed during a particular tax year only if, during the preceding tax year, the individual's self-employment income, as determined by the IRS, from work related to the employer that offers the group health coverage was at least equal to the amount specified in [§211\(b\)\(2\)](#) of the Act, which defines self-employment income for Social Security purposes. Self-employed individuals include persons such as consultants, owners of businesses, directors of corporations, and members of the clergy and religious orders who are paid for their services by a religious body or other entity.

**Set Aside Arrangement** – An administrative mechanism used to set-aside monies for Medicare including a self-administered arrangement (State law permitting). Set-aside arrangements are used in WC commutation cases, where an injured individual is disabled by the event for which WC is making payment, but the individual will not become entitled to Medicare until some time after the WC settlement is made. In such cases, Medicare greatly increases the likelihood that no Medicare payment is made until the set-aside arrangement's funds are depleted. These set-aside arrangements provide both Medicare and its beneficiaries security with regard to the amount that is to be used to pay for an individual's disability related expenses. Set-aside arrangements are **only** used in WC cases that possess a commutation aspect; they are not used in WC cases that are strictly or solely compromise cases.

**SSI** - Supplemental Security Income for the Aged, Blind and Disabled is the Federal subsistence income maintenance program for eligible individuals. Title XVI of the Social Security Act enacted SSI in 1972 for the purpose of assuring a minimum level of income for people who are age 65 or over, blind, or disabled, and who do not have sufficient income and resources to maintain a standard of living at the established Federal minimum income level.

**Self-Insured Plan** - A plan under which an individual, or a private or governmental entity, carries its own risk instead of taking out insurance with a carrier. The term includes a plan of an individual or other entity engaged in a business, trade, or profession, a plan of a nonprofit organization such as a social, fraternal, labor, educational, religious, or professional organization, and the plan established by the Federal government to pay for liability claims under the Federal Tort Claims Act. (With regard to FTCA claims, CMS attempts to collect its mistaken payment from the Federal agency that is settling the claim. If a resolution cannot be reached, CMS must submit the conflict to the Department of Justice for resolution.)

**Settlement** - An adjustment or agreement by which parties having a dispute between them reach or ascertain what each owes the other. In the MSP liability context, settlement refers to a monetary amount from a liability insurer agreed to by a party in satisfaction of a liability dispute.

**Spouse** – Means any individual who has spousal coverage under the employer plan.

**Statute of Limitations** - A specific time period after the right to assert a claim begins within which certain claims must be filed, and after which the claim may no longer be enforced.

**Subrogation** - Subrogation means the substitution of one person or entity for another. Under the Medicare subrogation provision, the program is a claimant against the responsible party and the liability insurer, to the extent that Medicare has made payments to or on behalf of the beneficiary.

**Third Party Payer (TPP)** - A WC law or plan, automobile or non-automobile no-fault insurance, any liability insurance, or a GHP or LGHP that is required to pay primary to Medicare.

**Under-insured Motorist Insurance** - Optional liability insurance available in some jurisdictions under which the policyholder's level of protection against losses caused by another is extended to compensate for inadequate coverage in the other party's policy or plan.

**Uninsured Motorist Insurance** - Liability insurance under which the policyholder's insurer pays for damages caused by a motorist who has no automobile liability insurance, carries less than the amount of insurance required by law, or is under-insured.

**Waiver** - The relinquishing of an established right. In an MSP situation, it is the forgiveness of the party's obligation to satisfy Medicare's claim, in whole or in part, if certain conditions are met.

**Workers' Compensation Agency** - The term "WC agency" means any governmental entity that administers a Federal or State WC law. This term includes WC commissions, industrial commissions, industrial boards, WC insurance funds, WC courts and, in the case of Federal WC programs, the U.S. Department of Labor.

**Workers' Compensation Carrier** - The term "WC carrier" means any insurance carrier authorized to write WC insurance under the state or federal law, the state compensation fund where the state administers the WC program, and the beneficiary's employer where the employer is self-insured.

**Workers' Compensation Law or Plan** - A WC law or plan is a government-supervised and employer-supported system for compensating employees for injury or disease suffered in connection with their employment, whether or not the injury was the fault of the employer. Workers' compensation does not usually cover agricultural employees, interstate railroad employees, employees of small businesses, employees whose work is

not in the course of the employer's business (e.g., domestic employees), casual employees, and self-employed people. Although WC programs were initially designed to cover accidental injuries suffered in the course of employment, all States now provide compensation for at least some occupational diseases as well.

**Working Aged** – Medicare is secondary to group health plans (GHPs) of employers and employee organizations, including multi-employer and multiple employer plans which have at least one participating employer that employs 20 or more employees. Medicare is secondary for Medicare beneficiaries age 65 or older who are covered under the plan by virtue of their own current employment status with an employer or the current employment status of a spouse of any age. .

**Wrongful Death** - A death caused by a wrongful act, neglect, or fault, as seen in some liability situations. See also Chapter 7, §50.5.4.1.1.

### **30 - Beneficiary's Rights and Responsibility**

(Rev. 1, 10-01-03)

#### **B3-3328.1**

##### **A - Beneficiary's Responsibility With Respect to GHPs that are Primary to Medicare**

(Rev. 1, 10-01-03)

**B3-3328.1, B3-3338.8, A3-3489.8, HO-262.14, SNF-334.6, HH-248.6**

The contractor will not make any Medicare payment if the beneficiary has not filed a claim or cooperated fully with the provider, physician or other supplier or the GHP. Also, the contractor will not make any Medicare payments until the beneficiary has exhausted the entire claims process including no-fault or liability insurance. Conditional benefits are not payable if payment cannot be made under no-fault or liability insurance because the beneficiary failed to file a proper claim (See [§20](#) for definition of proper claim.) unless the failure to file a proper claim is due to mental or physical incapacity of the beneficiary. A beneficiary need not file any appeal if not inclined to do so.

##### **B - Beneficiary's Right to Take Legal Action Against A GHP**

(Rev. 1, 10-01-03)

**B3-3328.12, B3-3338.9, A3-3490.15, A3-3492.G, A3-3489.9, A3-3407.10, A3-3491.16, B3-2370.11, HO-262.15, HO-263.16, HO-264.16, HO-289.10, SNF-334.7, SNF-336.16, SNF-335.16, HH-248.7, HH-253.15, HH-252.16, SNF-326.4, HH-250.10, HH-337, A3-3490.15**

[Section 1862\(b\)\(3\)\(A\)](#) of the Act provides that any claimant (including a beneficiary, provider, physician, or supplier) has the right to take legal action against, and to collect

double damages from a GHP, that fails to pay primary benefits for services covered by the GHP. Any claimant, also, has the right to take legal action against, and to collect double damages from, a no-fault or liability insurer that fails to pay primary benefits for services covered by the no-fault or liability insurer where required to do so under §1862(b) of the Act.

## **40 - Effect of GHPs Payments on Deductible, Coinsurance, and Utilization**

**(Rev. 1, 10-01-03)**

**A3-3491.8, A3-3418.1.A-B, A3-3490.9, A3-3490.10, A3-IM 3497.7, A3-3489.B, B3-3328.22, B3-3338.B, A3-3497.7, A3-3491.12, HO-262.1, HO-262.8, HO-263.9, HO-264.12, HO-264.13, B3.3329.3, SNF-335.12, SNF-336.9, HH-252.13, HH-253.9, HO-263.12, SNF-336.12, SNF-335.13**

Expenses that serve to meet the beneficiary's Part A or Part B cash and blood deductibles, if Medicare were primary payer, are credited to those deductibles even if the expenses are reimbursed by a GHP. This is true even if the GHP paid the entire bill and there is no secondary Medicare benefit payable. If a GHP paid for Medicare covered expenses in whole or in part, the Part B deductible is credited on the basis of the Medicare fee schedule amount rather than the amount paid by the GHP. Also, GHP payments to a provider are applied to satisfy a beneficiary's obligation to pay a Part A or Part B coinsurance amount. However, GHP payments are credited to deductibles before being used to satisfy the coinsurance.

Where no Medicare secondary benefit is payable, no utilization is charged the beneficiary. Where a Medicare secondary payment is made, the contractor charges the beneficiary with utilization in accordance with Chapter 3, §40.1.1. These procedures are applicable for calculating utilization for stays for which Medicare is secondary only for a portion of the stay.

Expenses for which payments are made and Medicare conditional payments are recovered from no-fault or liability insurance are credited toward the deductible amounts for both Parts A and B. Also, no-fault and liability payments are applied to satisfy a beneficiary's obligation to pay Part A or Part B coinsurance amounts. No-fault and liability payments are credited to deductibles before being used to satisfy the coinsurance. For services provided prior to November 13, 1989, payments by the primary payer are **not** counted toward the Medicare deductible. The discharge date is used for determining when a provider furnished the services.

Services for which Medicare conditional payments are recovered from liability or no-fault insurance are not counted against the number of inpatient care days available to the beneficiary. If an individual is hospitalized twice in the same benefit period and Medicare recovers its payment from a no-fault or liability insurance for the first hospitalization, the first hospitalization would not be charged to the beneficiary.

### **EXAMPLE 1**

An individual who previously had not met any of the \$100 Part B deductible incurred \$100 in charges for which the GHP paid \$50. The Medicare fee schedule amount was \$100. No Medicare benefits are payable. The individual is credited with \$100 toward the Part B cash deductible.

The beneficiary can be charged \$50. (The \$100 fee schedule amount minus the sum of the \$50 primary payment plus the \$0 Medicare payment). (See Chapter 3, §10.2.2.)

### **EXAMPLE 2**

An individual who previously had met \$20 of the \$100 Part B deductible incurred \$80 in charges that were paid in full by the GHP. The Medicare fee schedule amount was \$50. No Medicare benefits are payable. The individual is credited with an additional \$50 toward the Part B cash deductible and now has satisfied a total of \$70.

The physician cannot bill the beneficiary because the sum total of the primary payment (\$80) and the Medicare payment (\$0) exceeds the fee schedule amount (\$50). (See Chapter 3, §10.2.2.)

## **40.1 - Crediting Deductible for Non-Inpatient Psychiatric Services**

**(Rev. 1, 10-01-03)**

### **B3-3328.22**

The Part B deductible for non-inpatient psychiatric services is credited on the basis of 62.5 percent of the Medicare fee schedule amount. This is because incurred expenses for non-inpatient psychiatric services are limited to 62.5 percent of the Medicare fee schedule amount. Accordingly, Medicare pays no more than 50 percent of the Medicare fee schedule amount for non-inpatient psychiatric services (i.e., 80 percent of 62.5 percent of the fee schedule amount). (The unmet Part B deductible reduces the percentage of the fee schedule amount payable by Medicare.) The maximum third party payment that can be credited to the Part B deductible for non-inpatient psychiatric services is \$160: \$100 (Part B deductible) divided by .625. (See Medicare Benefit Policy, Chapter 16, §50 and 50.1.) There is no annual limit on incurred expenses for non-inpatient psychiatric services.

### **EXAMPLE 1**

An individual received non-inpatient psychiatric services for which a physician charged \$120. The \$100 Part B deductible had not been met. The GHP allowed \$100 and paid \$50. The Medicare fee schedule amount is \$110. The unmet Part B deductible is credited with \$68.75 (62.5 percent of \$110 = \$68.75). Since this amount is insufficient to meet the Part B deductible, the Medicare secondary benefit calculated in accordance with Chapter 5, §40.7.2 is \$0.

The beneficiary can be charged \$60 (the \$110 fee schedule amount minus the sum of the \$50 primary payment plus the \$0 Medicare payment). (See Chapter 3, §10.2.2.) The beneficiary still must meet \$32.25 of the annual Part B deductible before Medicare benefits become payable.

## **EXAMPLE 2**

An individual received non-inpatient psychiatric services for which the physician charged \$250. None of the individual's Part B deductible had been met. The GHP allowed charges in full and paid \$250. The Medicare fee schedule amount for the services was \$200. No Medicare secondary benefit is payable since the GHP paid charges in full. The \$100 Part B deductible is credited in full by the first \$160 of the fee schedule amount ( $62.5 \text{ percent} \times \$160 = \$100$ ).

The beneficiary cannot be billed by the physician because the sum total of the primary payment (\$250) and the Medicare payment (\$0) exceeds the fee schedule amount (\$200). (See Chapter 3, §10.2.2.)

## **EXAMPLE 3**

An individual received non-inpatient psychiatric services from a physician for which the physician charged \$500. None of the individual's \$100 Part B deductible had been met. A GHP allowed charges in full and paid \$400 (80 percent of the \$500). The Medicare fee schedule amount for the services was also \$500. The \$100 Part B deductible is credited in full by the first \$160 of the fee schedule amount ( $62.5 \text{ percent} \times \$160 = \$100$ ). The Medicare secondary benefit calculated in accordance with Chapter 3, §10.2.2 is \$100.

The physician cannot bill the beneficiary because the sum total of the primary payment (\$400) and the Medicare secondary payment (\$100) equals the physician's charges.

## **50 - Rules Defining Employees Covered by GHPs and LGHPs**

**(Rev. 1, 10-01-03)**

**B3-3329.3, A3-3491.1.B, HO-263.2, SNF-336.2, HH-253.2, B3-3329.3A, B3-3336.8, A3-3492.B.3**

### **A - Current Employment Status**

An individual has current employment status if the individual is:

- Actively working as an employee, is the employer (including a self-employed person), or is associated with the employer in a business relationship; or
- The individual is not actively working and is receiving disability benefits from an employer for up to 6 months (the first 6 months of employer disability benefits are subject to FICA taxes); or not actively working but meets **all** of the following conditions:

- o Retains employment rights in the industry;
- o Has not had their employment terminated by the employer if the employer provides the coverage or has not had his/her membership in the employee organization terminated if the employee organization provides the coverage;
- o Is not receiving disability benefits from an employer for more than 6 months;
- o Is not receiving Social Security disability benefits; and
- o Has employment-based GHP coverage that is not COBRA continuation coverage. (See 29 U.S.C. 1161-1168.)

A person aged 65 or older and receiving disability payments from an employer is considered to have current employment status if such payments are subject to taxes under FICA. Employer disability payments are subject to FICA tax for the first six months of disability after the last calendar month in which the employee worked for that employer.

### **EXAMPLE**

Adam Green stopped working because of disability in December 1999 at age 66. His employer began paying him disability payments January 2000. Since disability payments are taxed under FICA for 6 months after the last month in which the employee worked, Medicare is the secondary payer through June 2000. Beginning with July 2000, Medicare becomes the primary payer as the disability payments are no longer considered wages under FICA.

## **B - Retain Employment Rights**

### **B3-3329.3.B, A3-3492B.3.b**

Persons who retain employment rights include but are not limited to:

- Those who are furloughed, temporarily laid off, or who are on sick leave;
- Teachers and seasonal workers who normally do not work throughout the year; and
- Those who have health coverage that extends beyond or between active employment periods (e.g., based on an hour's bank arrangement). (Active union members in certain trades and industries (e.g., construction) often have hours' bank coverage.)



## **C - Coverage by Virtue of Current Employment Status**

### **B3-3329.3.C, A3-3492.B.3.c**

An individual has coverage as a result of current employment status with an employer if the individual has:

- GHP or LGHP coverage based on employment, including coverage based on a certain number of hours worked for that employer or a certain level of commissions earned from work for that employer at any time; and
- Current employment status with that employer, as defined in subsection 30.A above.

## **50.1 - Clarification of Current Employment Status for Specific Groups**

**(Rev. 1, 10-01-03)**

### **A - Member of Religious Order**

**B3-3329.3.D-E, A3-3491, A3-IM 3491, HO-263, SNF-336, HH-253, A3-3492.B.3.e**  
**(section d was deleted with a comment)**

A member of a religious order whose members are required to take a vow of poverty is not considered to have current employment status with the religious order if the services he/she performs as a member of the order are considered employment by the order for Social Security purposes only. This is because the religious order elected Social Security coverage for its members under section 3121(r) of the Internal Revenue **Member of Religious Order** Code. Thus, Medicare is primary payer to any group health coverage provided by the religious order.

This exception applies only to members of religious orders who have taken a vow of poverty. It does not apply to clergy or to any member of a religious order who has not taken a vow of poverty or to lay employees of the order. This exception applies not only to services performed for the order itself (such as administrative, housekeeping, and religious services), but also to services performed at the direction of the order for employers outside of the order provided that the outside employer does not provide the member of the religious order with its own group health plan coverage. A member of a religious order has current employment status with the outside employer as a result of providing services on behalf of the outside employer (an ongoing business relationship exists). If the outside employer provides group health plan coverage to the member of the religious order on the basis of that current employment status relationship, the usual Medicare Secondary Payer rules apply.

Medicare is the secondary payer to the group health plan of the outside employer if the outside employer has the requisite number of employees.

## **EXAMPLE 1**

Sister Mary Agnes is a member of a religious order where members are required to take a vow of poverty. Sister Mary Agnes was assigned to teach at a church school in the Diocese of the Metropolis. The Diocese does not provide group health plan coverage to Sister Mary Agnes. The only group health coverage available to Sister Mary Agnes is provided by the religious order. Medicare is the primary payer for services provided to Sister Mary Agnes.

## **EXAMPLE 2**

Sister Mary Teresa is a member of a religious order whose members are required to take a vow of poverty. Sister Mary Teresa was assigned to teach at a church school in the Diocese of Smallville. On the basis of her teaching relationship with the Diocese of Smallville, the Diocese provides group health plan coverage to Sister Mary Teresa. The group health plan provided by the Diocese of Smallville is the primary payer and Medicare is the secondary payer for services provided to Sister Mary Teresa.

Carriers should note that the exemption only applies to the working aged and disability provisions that base a group health plan's obligation to be a primary payer on a current employment status relationship. The exception does not apply to the ESRD, workers compensation or liability and no-fault provisions.

## **B - Insurance Agents**

### **B3-3329.3.F, A3-3492.B.3.f**

The following guidelines apply in determining the status of insurance agents. (See §20, [definition of GHP](#) to determine when an insurance company's plan meets the definition of a GHP.)

A self-employed insurance agent is considered to have coverage based on current employment status if the agent:

- (1) Has an "active agent" relationship with the company; or
- (2) Has a "retired agent" relationship with the company and has reached the "earning threshold" of \$400 or more pursuant to §211(b) of the Act. The fact that a self-employed insurance agent is authorized to represent the company, e.g., to write policies on behalf of the company, does not itself imply current employment status.

## **C - Senior Federal Judges**

### **B3-3329.3.G, A3-3492.B.3.g**

Senior Federal judges are retired judges of the U.S. court system and the Tax Court. They may continue to adjudicate cases, but they are entitled to full salary as a retirement

benefit whether or not they perform judicial services for the Government. By law, the remuneration they receive as senior judges is not considered wages for Social Security retirement offset purposes. Since they are considered retired for Social Security purposes, they are not considered to have current employment status for purposes of the working aged and disability provisions.

## **D - Volunteers**

### **B3-3329.3.H, A3-3492.B.3.h**

Volunteers are not considered to have current employment status unless they perform services or are available to perform services for an employer and receive remuneration for their services. For example, for purposes of [§1862\(b\)](#) of the Act, VISTA volunteers are considered to have current employment status since they receive remuneration from the Federal Government. Also, remuneration may be of a monetary or nonmonetary nature. Benefits, including health benefits that a volunteer receives, are considered remuneration.

## **E - Directors of Corporations**

### **B3-3329.3.I, A3-3492.B.3.i**

Directors of corporations (i.e., persons serving on a Board of Directors of a corporation who are not officers of the corporation) are self-employed. (Officers of a corporation are employees.) Directors who receive remuneration for serving on a board are considered to have current employment status. Remuneration may be of a monetary or nonmonetary nature. Benefits, including health benefits that a corporation provides to a board member, are considered remuneration if they are subject to FICA taxes under the IRC.

Directors who receive no remuneration for serving on the Board (unpaid directors) are not considered to have current employment status. However, remuneration may consist of deferred compensation (i.e., amounts earned but not payable until some future date usually when the individual reaches age 70 and is no longer subject to the Social Security retirement test). A director receiving deferred compensation is considered to have current employment status only while serving as a director. (See subsection F.)

## **F - Individuals Receiving Delayed Compensation Payments Subject to FICA Taxes**

### **B3-3329.3.K**

An individual who is not working is not considered to have current employment status solely on the basis of receiving delayed compensation payments for previous periods of work despite the fact that those payments are subject to FICA taxes (or would be subject to FICA taxes if the employer were not exempt from paying those taxes). For example, an individual who is not working and in 2003 receives payments subject to FICA taxes for work performed in 2002 is not considered to be an employee in 2003 solely on the basis of receiving those payments.

## **G - Leased Employees**

Leased employees (as defined in §414(n)(2) of the IRC) are treated as employees of the recipient. The term "leased employee" means any person who is not an employee of the recipient of the services but who provides services to the recipient if the:

- Services are provided based on an agreement between the recipient and any other person (i.e., the leasing organization);
- Person has performed such services for the recipient on a substantially full-time basis for at least 1 year. (In general, an employee who works 30 hours or more is considered to be full time.); and
- Services are of a type historically performed in the business field of the recipient by employees. An example of a leased employee is an employee of a temporary agency who is assigned to work full time for at least one year doing bookkeeping for an accounting firm.

In implementing these provisions, CMS relies on the regulations and decisions made by the Secretary of the Treasury. Specific questions relating to application of these provisions may be directed to the appropriate CMS RO.

## **H - Re-employed Retirees and Annuitants**

### **A3-3491.2, B3-3336.7**

If a retiree or annuitant returns to work even for temporary periods, the employer is required to provide the same coverage under the same conditions that is furnished to other employees (i.e., non-retirees). Thus, an employer is required to provide primary coverage for a re-employed retiree if the amount of work the individual performs (based on hours, productivity, etc.) would be sufficient to earn the employee coverage from the employer had the employee not retired. The GHP or LGHP coverage is primary to Medicare because of the current employment status. This rule applies even if the:

- Plan is the same plan that previously provided coverage to the individual retiree or annuitant;
- Premiums for the plan are paid from a retirement pension or fund; or
- Re-employed retiree pays the entire premium.

## **I - Coverage for Self-Employed Individuals**

### **B3-3336.6**

When Medicare is secondary payer, the employer is not required to provide GHP coverage to self-employed individuals. However, if an employer subject to the MSP provisions provides coverage to a self-employed individual (including owners, a

consultant, or a contractor), the employer may not take into account the individual's Medicare entitlement (i.e., the GHP must pay primary to Medicare).

## **60 - Aggregation Rules Applicable to Determine the Employer Size**

**(Rev. 1, 10-01-03)**

### **B3-3329.3.J.1, B3-3329.3.J.2**

The size of the employer is a factor in determining whether Medicare is secondary or primary payer under the working aged and disability provisions of the law. For MSP purposes, the employer is the legal entity that employs the employees. For example, the employer may be an individual, a partnership, or a corporation. Ordinarily, the identity of that entity is clear.

There are situations, however, when it is not clear which corporation or individual is the employing entity for MSP purposes. For example, when a corporation is owned or controlled by another corporation, it must be decided which corporation is the employer. Similarly, when related individuals each have businesses and each claim to be a separate employer with either fewer than 20 or fewer than 100 employees, it must be decided whether the individuals are separate employers or a single employer.

The MSP law contains the following rules for determining the size of the employer under the MSP for the aged and disabled provisions.

### **A - Single Employers**

#### **B3-3329.3J.2.A**

Single employers under Section §52 of the IRC are defined as follows:

- All employers that are treated as single employers under subsections (a) or (b) of §52 of the IRC are treated as single employers;
- Section 52(a) of the IRC provides that all employees of all corporations that are members of the same controlled group of corporations are treated as if employed by a single employer; and,
- Section 52(b) of the IRC provides that all employees of trades or businesses (whether or not incorporated), e.g., employees of partnerships or proprietorships that are under common control, shall be treated as employed by a single employer.

In general, two or more individuals or corporations are considered to be separate employers under §52(a) or (b) of the IRC if they file separate income tax returns. Two or more individuals are considered to be a single employer if they file a consolidated tax return.

When there is a question about the tax status of a particular employer that claims to have fewer employees than the 20 or 100 employee thresholds, contractors must request the employer to submit copies of its most recent tax return to resolve the question.

## **B - Affiliated Service Groups**

### **B3-3329.3.J.2.b**

All employees of the members of an affiliated service group (as defined in Section 414(m) of the IRC) are treated as employed by a single employer.

## **C - Treatment of Religious Organizations**

### **B3-3329.3.J.3**

The CMS does not aggregate religious organizations for MSP purposes. Incorporated parishes and churches that are part of a church-wide organization, such as a diocese or synod, are considered to be individual employers. A GHP or LGHP for employees of such parishes or churches is considered to be a multi-employer GHP. (See Chapter 2, §10.4 and §30.3, for policies regarding multi-employer GHPs in which at least one participating employer employs 20 or 100 or more employees respectively.)

## **70 - Prohibitions Applicable to Employers Offering GHP Coverage**

(Rev. 1, 10-01-03)

**B3-3329.5, B3-3329.5.A-B, B3-3336.2-3**

### **70.1 - Financial Incentives**

(Rev. 1, 10-01-03)

#### **B3-3329.5**

An employer or other entity is prohibited from offering Medicare beneficiaries financial or other benefits as incentives not to enroll in or to terminate enrollment in a GHP or LGHP that is or would be primary to Medicare. This prohibition precludes the offering of benefits to Medicare beneficiaries that are alternatives to the employer's primary plan (e.g., prescription drugs) unless the beneficiary has primary coverage other than Medicare. An example would be primary plan coverage through his/her own or a spouse's employer. This rule applies even if the payments or benefits are offered to all other individuals who are eligible for coverage under the plan. It is a violation of the Medicare law every time a prohibited offer is made regardless of whether it is oral or in writing. Any entity that violates the prohibition is subject to a civil money penalty of up to \$5,000 for each violation.

## **70.2 - Discrimination in Offering Equal Benefits for Older and Younger Employees and Spouses**

(Rev. 1, 10-01-03)

**A3-3491, B3-3336.3, B3-3329.6.B, A3-IM 3491.B.2, HO-263, SNF-336, HH-253**

Section [1862\(b\)\(1\)\(A\)\(i\)\(II\)](#) of the Act provides that GHPs of employers of 20 or more employees must provide to any employee or spouse age 65 or older the same benefits under the same conditions that they provide to employees and spouses under 65 if those 65 or older are covered under the plan on the basis of the individual's current employment status or the current employment status of a spouse of any age. The requirement applies regardless of whether the individual or spouse 65 or older is entitled to Medicare.

## **70.3 - Differentiation for ESRD**

(Rev. 1, 10-01-03)

**B3-3329.6.C, B3-3335.2, A3-3490.14**

A GHP may not take into account that an individual is eligible for or entitled to Medicare benefits on the basis of ESRD during a coordination period described in Chapter 2, §20.1.1 or §20.1.4. The following are examples of potential taking into account the Medicare eligibility or entitlement of ESRD patients:

- The plan does not cover routine maintenance dialysis services or kidney transplants;
- The plan excludes benefits, makes itself secondary to government benefits, or charges a higher premium for individuals with ESRD;
- The plan imposes limitations on benefits for persons with ESRD which are not applicable to others, e.g., a higher deductible or coinsurance, a longer waiting period or a lower annual or lifetime benefit limit.

Section [1862\(b\)\(1\)\(C\)\(ii\)](#) of the Act provides that GHPs may not differentiate in the benefits they provide between individuals who do not have ESRD and other individuals covered under the plan on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner. Actions that constitute differentiation in plan benefits (and that may also constitute "taking into account" Medicare eligibility or entitlement) include, but are not limited to, the following:

- Terminating coverage of individuals with ESRD for reasons that would not be a basis for terminating individuals who do not have ESRD;
- Imposing benefit limitations (such as less comprehensive health plan coverage, reductions in benefits, exclusion of benefits, a higher deductible or coinsurance, a

longer waiting period, a lower annual or lifetime benefit limit, or more restrictive preexisting illness limitations) on persons who have ESRD but not on others enrolled in the plan;

- Charging individuals with ESRD higher premiums;
- Paying providers/suppliers less for services furnished to individuals who have ESRD than for the same services furnished to those who do not have ESRD, such as paying 80 percent of the Medicare rate for renal dialysis on behalf of a plan enrollee who has ESRD and the usual, reasonable, and customary charge for renal dialysis on behalf of an enrollee who does not have ESRD; and
- Failing to cover routine maintenance dialysis or kidney transplants when a plan covers other dialysis services or other organ transplants.

A plan is not prohibited from limited covered utilization of a particular service as long as the limitation applies uniformly to all plan enrollees. For instance, if a plan limits its coverage of renal dialysis sessions to 30 per year for all plan enrollees, the plan would not be differentiating in the benefits it provides between plan enrollees who have ESRD and those who do not.

### **70.3.1 - Paying Benefits Secondary to Medicare**

(Rev. 1, 10-01-03)

#### **B3-3335.2.D, A3-3690.14D**

The nondifferentiation provision does not prohibit a plan from paying benefits secondary to Medicare after the coordination period. However, a plan may not otherwise differentiate, as described in [§70.2](#) and [§70.3](#), in the benefits it provides.

#### **EXAMPLE 1**

Mr. Smith works for employer A and he and his wife are covered through employer A's GHP (Plan A). Neither is eligible for Medicare nor has ESRD. Mrs. Smith works for employer B and is also covered by employer B's plan (Plan B). Plan A is more comprehensive than Plan B and covers certain items and services, such as prescription drugs, which Plan B does not cover. If Mrs. Smith obtains a medical service, Plan B pays primary and Plan A pays secondary. That is, Plan A covers Plan B copayment amounts and items and services that Plan A covers but that Plan B does not.

Mr. Jones also works for employer A and he and his wife are covered by Plan A. Mrs. Jones does not have other GHP coverage. Mrs. Jones develops ESRD and becomes entitled to Medicare on that basis. Plan A pays primary to Medicare during the first 30 months of Medicare entitlement based on ESRD. When Medicare becomes the primary payer, the plan converts Mrs. Jones' coverage to a Medicare supplemental policy. That policy pays Medicare's deductible and coinsurance amounts but does not pay for items and services not covered by Medicare which Plan A would have covered. That



conversion is impermissible because the plan is providing a lower level of coverage for Mrs. Jones who has ESRD than it provides for Mrs. Smith who does not. In other words, if Plan A pays secondary to primary payers other than Medicare, it must provide the same level of secondary benefits when Medicare is primary in order to comply with the nondifferentiation provision.

## **70.4 - Taking Into Account Medicare Entitlement**

**(Rev. 1, 10-01-03)**

**B3-3329.6.A, B3-3335.2.A, A3-3491.1, B3-3336.2, A3-3490.14, A3-IM 3491.B.1, HO-263.2, SNF-336.2, HH-253.2**

Sections [1862\(b\)\(1\)\(A\), \(B\), and \(C\)](#) of the Act provide that GHPs and LGHPs may not take into account that an individual is entitled to Medicare in any of the following situations:

- Beneficiaries age 65 or older who are covered by a GHP (of employers who employ at least 20 employees) by virtue of the individual's current employment status or the current employment status of a spouse of any age (see Chapter 2, §10);
- Beneficiaries who are eligible for or entitled to Medicare on the basis of ESRD and who are covered by a GHP (without regard to the number of individuals employed and regardless of current employment status) during the first 30 months of ESRD-based Medicare eligibility or entitlement (see Chapter 2, §20); or
- Beneficiaries under age 65 who are entitled to Medicare on the basis of disability and who are covered under a LGHP (i.e., a plan of an employer who employs at least 100 employees) and are covered under the plan by virtue of the individual's or a family member's current employment status. (See Chapter 2, §30)

### **A - Examples of Actions that Constitute "Taking Into Account" Medicare Entitlement**

#### **B3.3329.6.D**

Actions by GHPs or LGHPs that constitute taking into account that an individual is entitled to Medicare on the basis of ESRD, age, or disability (or eligible on the basis of ESRD) include, but are not limited to, the following:

- Failing to pay primary benefits;
- Offering to individuals entitled to Medicare coverage that is secondary to Medicare;
- Terminating coverage because the individual has become entitled to Medicare, except as permitted under COBRA continuation coverage provisions (see 26

U.S.C. Section 4980B(f)(2)(B)(iv); 29 U.S.C. Section 1162(2)(D); and 42 U.S.C. Section 300bb-2 (2)(D));

- In the case of a LGHP, denying or terminating coverage because an individual is entitled to Medicare on the basis of disability without denying or terminating coverage for similarly situated disabled individuals who do not meet the Social Security definition of disability;
- Imposing limitations (such as providing less comprehensive health care coverage, excluding benefits, reducing benefits, charging higher deductibles or coinsurance, or providing for lower annual or lifetime benefit limits or more restrictive preexisting illness limitations) on benefits for a Medicare-entitled individual that do not apply to others enrolled in the plan;
- Charging the Medicare-entitled individual higher premiums;
- Requiring a Medicare-entitled individual to wait longer for coverage to begin;
- Paying providers and suppliers no more than the Medicare payment rate for services furnished to a Medicare beneficiary but making payments at a higher rate for the same services to an enrollee who is not entitled to Medicare;
- Providing misleading or incomplete information that could have the effect of inducing a Medicare-entitled individual to reject the employer plan, thereby making Medicare the primary payer. (An example of this would be informing the beneficiary of the right to accept or reject the employer plan but failing to inform the individual that if he/she rejects the plan, the plan will not be permitted to provide or pay for secondary benefits.);
- Including in its health insurance cards, claims forms, or brochures distributed to beneficiaries, providers, and suppliers instructions to bill Medicare first for services furnished to Medicare beneficiaries without stipulating that such action may be taken only when Medicare is the primary payer; and
- Refusing to enroll an individual for whom Medicare would be secondary payer when enrollment is available to similarly situated individuals for whom Medicare would not be secondary payer.

## **70.5 - Permissible Distinctions in Coverage Allowed a GHP or LGHP**

**(Rev. 1, 10-01-03)**

### **B3-3335.2.C, B3-3329.6.E**

A plan is not prohibited from limiting covered utilization of a particular service as long as the limitation applies uniformly to all plan enrollees. For instance, if a plan limits its coverage of renal dialysis sessions to 30 per year for all plan enrollees, the plan would

not be differentiating in the benefits it provides between plan enrollees who have ESRD and those who do not.

If a GHP or LGHP makes benefit distinctions between various categories of individuals (distinctions unrelated to the fact that an individual is entitled to Medicare but based, for instance, on length of time employed, occupation, or marital status), the GHP or LGHP plan may make the same distinctions between the same categories of individuals entitled to Medicare whose plan coverage is based on current employment status. For example, if a GHP or LGHP does not offer coverage to employees who have worked less than one year and who are not entitled to Medicare on the basis of disability or age, the GHP or LGHP is not required to offer coverage to employees who have worked less than one year and who are entitled to Medicare on the basis of disability or age.

- A GHP or LGHP may pay benefits secondary to Medicare for an aged or disabled beneficiary who has current employment status if the employer employs fewer than 20 or 100 employees, respectively.
- A GHP or LGHP may pay benefits secondary to Medicare for an aged or disabled beneficiary who has current employment status if the plan coverage is COBRA continuation coverage because of reduced hours of work. Medicare is primary payer for this beneficiary because, although he/she has current employment status, the GHP or LGHP coverage is by reason of the COBRA law rather than by virtue of current employment status.
- A GHP may terminate COBRA continuation coverage of an individual who becomes entitled to Medicare on the basis of ESRD when permitted under the COBRA provisions. The only exception in the COBRA law (see 29 U.S.C.1162(2)(D)(ii)) prohibits GHPs from terminating COBRA coverage for retirees and dependents who are entitled to Medicare when the employee retired before the employer effectively terminated the regular plan coverage by filing for bankruptcy.

## **80 - Actions Resulting from GHP or LGHP Nonconformance**

**(Rev. 1, 10-01-03)**

**B3-3329.6.G, B3-3329.7, B3-3329.8, A3-3492.H, A3-3496, SNF-337**

### **A - Determination**

A determination of nonconformance is a CMS determination that a GHP or LGHP is a nonconforming plan as provided in this section. The CMS may make a finding of nonconformance for any GHP or LGHP that at any time during a calendar year fails to comply with any of the following statutory provisions:

- The prohibition against taking into account that a beneficiary who is covered or seeks to be covered under the plan is entitled to Medicare on the basis of ESRD, age, or disability or eligible on the basis of ESRD (see [§70.4](#) above);
- The equal benefits clause for the working aged (see [§70.5](#) above);
- The nondifferentiation clause for individuals with ESRD ((see [§70.3](#) above); or
- The obligation to refund conditional Medicare primary payments. (See Chapter 7, §10.1.)

The CMS may make a finding of nonconformance for a GHP or LGHP that fails to provide correct, complete, and timely information, either voluntarily or in response to a CMS request, on the plan's primary payment obligation with respect to a given beneficiary if that failure contributes to:

- Medicare mistakenly making a primary payment; or
- A delay or foreclosure of CMS's ability to recover a mistaken primary payment.

If CMS determines that a GHP fails to comply with the provision that prohibits taking into account entitlement to Medicare (see [§70.4](#)) in a particular year, the GHP is nonconforming for that year. If, in a subsequent year, that plan fails to repay the resulting mistaken primary payments, the plan is also nonconforming for the subsequent year. For example, if a plan paid secondary for the working aged in 2000, that plan was nonconforming for 2000. If in 2003 CMS identifies mistaken primary payments attributable to the 2000 violation and the plan refuses to repay, it is also nonconforming for 2003.

## **B - Starting Dates for Determination of Nonconformance**

### **B3-3329.6.I**

The CMS's authority to determine nonconformance of GHPs and LGHPs begins on the following dates:

- January 1, 1987, for MSP provisions that affect the disabled;
- December 20, 1989, for MSP provisions that affect ESRD beneficiaries and the working aged; and
- August 10, 1993, for failure to refund mistaken Medicare primary payments.

## **C - Notice to GHP or LGHP of Determination of Nonconformance**

If CMS Central Office determines that a GHP or a LGHP is nonconforming with respect to a particular calendar year, CMS will mail a written notice to the plan with the following:

- The determination;
- The basis for the determination;
- The right of the parties to request a hearing. (The Parties are the GHP or LGHP for which CMS determined the nonconformance and any employers or employee organizations that contributed to the plan during the calendar year for which CMS determined nonconformance.);
- An explanation of the procedure for requesting a hearing;
- The tax that may be assessed by the IRS in accordance with §5000 of the IRC; and
- The fact that, if none of the parties requests a hearing within 65 days from the date on the notice, the determination is binding on all parties unless it is reopened.

The notice also states that the plan must submit to CMS, within 30 days from the date on its notice, the names and addresses of all employers and employee organizations that contributed to the plan during the calendar year for which CMS has determined nonconformance.

#### **D - Notice to Contributing Employers and Employee Organizations**

The CMS mails written notice of the determination, including all the information specified in [subsection C](#), above, to all contributing employers and employee organizations already known to CMS or identified by the plan in accordance with subsection C. Employer and employee organizations have 65 days from the date of their notice to request a hearing.

#### **E - Penalties**

##### **B3-3329.5.B, B3-3329.7, B3-3329.8, A3-3492.H, A3-3496 A3-349.2.H**

Any entity that violates the prohibition described in [subsection A](#) is subject to a civil money penalty of up to \$5,000 for each violation.

If CMS Central Office determines that a plan has been a nonconforming GHP in a particular year, it refers its determination, including the identity of the contributors that it has identified, to the IRS, but only after the parties have exhausted all appeal rights with respect to the determination. Section 5000 of the Internal Revenue Code of 1986 imposes an excise tax penalty on employers and employee organizations that contribute to nonconforming GHPs. They are taxed 25 percent of the employer's or employee organization's expenses incurred during the calendar year for each GHP (conforming as well as nonconforming) to which they contribute. This tax penalty does not apply to Federal and other governmental employers. The IRS administers Section 5000 of the IRC, which imposes the tax on employers (other than governmental entities) or employee organizations that contribute to a nonconforming GHP mentioned in [§80](#).

## **90 - GHP or LGHP Actions to Document Conformance**

**(Rev. 1, 10-01-03)**

### **B3-3329.6.G, A3-3490.14**

A GHP or LGHP may be required to demonstrate that it has complied with the MSP prohibitions and requirements set forth in [§70](#) and to submit supporting documentation. If the GHP or LGHP fails to provide acceptable documentation, the GHP or LGHP could be found to be nonconforming. The contractor must notify the RO and furnish complete information.

#### **A - Examples**

The following are examples of acceptable documentation:

- A copy of the employer's plan or policy that specifies the services covered, conditions of coverage, and benefit levels and limitations with respect to persons entitled to Medicare on the basis of ESRD, age, or disability for whom Medicare is secondary payer, as compared to the provisions applicable to other enrollees and potential enrollees; and
- An explanation of the plan's allegation that it does not owe CMS any amount CMS claims the plan owes as refund for conditional or mistaken Medicare primary payments. The plan must include all information requested by the contractor.

## **100 - Referral to the Regional Office**

**(Rev. 1, 10-01-03)**

### **A3-3492.K, B3-3329.5.C, B3-3329.6.H, A3-IM 3491.C, HH-337, A3-3492.J**

Since the CMS is responsible for enforcement of the age anti-discrimination provisions for coverage under group health plans, all complaints received that may reflect such discrimination by GHPs must be treated as possible violations of the Medicare law. This includes complaints that a GHP is "taking into account" that an individual is entitled to Medicare benefits and complaints that a GHP is not providing equal benefits under the same conditions for older and younger workers and spouses.

Contractors must refer any cases to the RO where a GHP or LGHP is a nonconforming plan. Cases are referred as a result of the GHP or LGHP performing the following actions:

- Offers secondary coverage for individuals for whom Medicare is secondary; or
- Refuses to reimburse Medicare for any primary benefits paid to, or on behalf of, a Medicare beneficiary.

In all potential discrimination cases, the contractor obtains documentation of the alleged discrimination, such as:

- A notice from the GHP and/or a copy of the plan policy;
- A written description of the alleged discriminatory action(s) by the GHP from the party or parties involved;
- The name and address of the individual's employer;
- The individual's name and HICN;
- The name and address of the GHP or LGHP;
- The individual's group health plan identification number; and
- A full explanation of the reasons for the referral.

All available information concerning the matter must be sent to the RO, along with an analysis of the facts. If the RO believes that the GHP may have committed a discriminatory act, the case is referred to the Central Office for consideration of whether the plan is a nonconforming group health plan, i.e. a group health plan which at any time during a calendar year does not comply with the anti-discrimination provisions of the Act. The RO considers possible legal action to collect double damages from the nonconforming LGHP/GHP. The CO also refers nonconforming group health plans to the Internal Revenue Service for imposition of an excise tax penalty to assure compliance with the anti-discrimination provisions of the law.

If the GHP, LGHP, or employer has agreed to discontinue offering secondary coverage to Medicare individuals for whom it is primary payer or has agreed to reimburse Medicare the amount of incorrect Medicare primary benefits that should have been paid by the plan, the CO includes this information in its referral.

Once the CO refers a nonconforming LGHP/GHP to the IRS, it does not withdraw the referral solely because the plan has discontinued offering improper secondary coverage or has reimbursed Medicare the amount of incorrect primary benefits Medicare paid.

## **100.1 - Job Discrimination**

**(Rev. 1, 10-01-03)**

### **A3-3490.14.B**

The CMS is responsible for investigating complaints of potential job discrimination against ESRD beneficiaries that may occur as a result of the law making Medicare secondary payer to GHPs. The CMS must report its findings to Congress periodically.

If contractors become aware of any employer or plan which in any way denies employment, or conditions or restricts employment or promotional opportunities, because an applicant or employee or a dependent of a job applicant or employee has ESRD, it refers the case to the RO, which investigates the complaint and sends a report to CO.

## **110 - Federal Government's Right to Sue and Collect Double Damages**

**(Rev. 1, 10-01-03)**

### **B3-3328.17, A3-3495**

Separate from its subrogation rights, the Federal Government has an independent right to take legal action to recover Medicare primary payments from entities that are required to or responsible for paying benefits primary to Medicare, but fail to meet the requirement or the responsibility. The Federal Government may recover double damages in this type of lawsuit pursuant to [§1862\(b\)\(2\)\(B\)\(ii\)](#) of the Act. Entities that are required or responsible to pay primary to Medicare include:

- GHPs, including insurers, employers, and third party administrators (TPAs) on behalf of such plans;
- LGHPs, including insurers, employers, and TPAs on behalf of such plans;
- Any automobile medical insurance plan;
- Any liability insurance policy or plan, including a self-insured plan;
- A WC plan; and
- An automobile or non-automobile no-fault insurance plan.

The contractor must refer to its servicing CMS RO any case in which an entity is required or responsible to make primary payment and to repay Medicare for mistaken primary payments but refuses to do so. It includes the following information in the referral:

- Beneficiary's name, address, and SSN or HICN;
- Formal name and address of the insurer or plan;
- Employee brochure that describes health benefits and coverage;
- Name and address of the entity required or responsible for making payment on behalf of the plan (e.g., the employer, an insurer, or a TPA);
- A copy of the employer's agreement with the TPA;
- Name of the sponsoring or contributing employer or employee organization;



- The provider/physician's/supplier's name, address, and identification number;
- The specific amount of mistaken primary benefits Medicare paid;
- The specific date(s) of service;
- The specific procedure or diagnosis code(s);
- The MSP type (e.g., ESRD or working aged); and
- A full explanation of the reasons for the referral.

The RO reviews the case file for completeness and obtains any needed additional information. When the file is complete, the RO refers the case to the CMS CO, where consideration is given to possible legal action to collect double damages from that entity.

The Government's right to collect double damages is effective for items and services furnished on or after December 20, 1989, under all MSP provisions except the MSP for the disabled provision. The Government's right to sue and collect double damages in a lawsuit under the MSP for the disabled provision is effective for items and services furnished on or after January 1, 1987.